

2005 -2006 Medical Benefits at a Glance

Plan Features	CIGNA Health Care (POS)		United Healthcare (PPO)	
	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Plan Deductible <i>(per calendar year)</i> Individual Family	\$0 \$0	\$200 \$600	\$300 \$900	\$600 \$900
Coinsurance Limit <i>(plus deductible, if applicable)</i> Individual Family	\$500 \$1,000	\$3,200 \$6,600	\$1,800 \$3,900	\$5,600 \$10,900
Lifetime Maximum	Unlimited	\$500,000	Unlimited	\$500,000
Physician Services <i>(except Mental Health/Alc/Drug)</i> Office Visits Routine Physicals Well Baby Care <i>(first year immunizations through age 6)</i> Routine Ob/Gyn Exam Routine Mammography Annual Prostate & Colonrectal Exam Preventive Care <i>(TB Test & Pneumonia shot)</i> <i>(Diabetes Testing & Medical Nutritional Counseling)</i> <i>Must be medically necessary</i> Specialists <i>(office visits)</i> Physician In-Hospital Services	100% after \$20 copay 100% after \$20 copay 100% after \$20 copay 100% after \$20 copay <i>(on a self-referred basis to a network provider)</i> 100% after \$20 copay 100% after \$20 copay 100% after \$20 copay 100% after \$25 copay 95%	50% after deductible Not covered 50% after deductible Not covered Not covered Not covered 50% after deductible 50% after deductible	85% after deductible Not covered 85% after deductible 85% after deductible Only Pap Smears as necessary 85% after deductible 1 per person per calendar year 85% after deductible Starting at age 40 85% after deductible 1 per person per calendar year 85% after deductible 85% after deductible	65% after deductible Not covered 65% after deductible 65% after deductible 1 per person per calendar year 65% after deductible Starting at age 40 65% after deductible 1 per person per calendar year 65% after deductible 65% after deductible
Diagnostic X-ray & Laboratory <i>(other than physician's office)</i>	95%	50% after deductible	85% after deductible	65% after deductible
Ambulance	95%	50% after deductible	80% after deductible	80% after deductible
Maternity	\$20 copay first visit	50% after deductible	85% after deductible	65% after deductible
Hospital Services Inpatient Coverage Outpatient Coverage Emergency Room Non-Emergency Use of Emergency Room	95% minus \$150 per confinement 95% 100% after \$75 emergency room copay <i>(waived if confined)</i> Not covered <i>(unless prior authorization by PCP)</i>	50% after deductible minus \$150 per confinement 50% after deductible 100% after \$75 emergency room copay <i>(waived if confined)</i> Not covered <i>(unless prior authorization by PCP)</i>	85% after deductible plus additional \$150 per confinement 85% after deductible 85% after deductible Additional \$75 copay <i>(waived if confined)</i> 85% after deductible Additional \$75 copay	65% after deductible plus additional \$150 per confinement 65% after deductible 65% after deductible Additional \$75 copay <i>(waived if confined)</i> 65% after deductible Additional \$75 copay
Skilled Nursing Facility	95% 70 day max	50% after deductible	85% after deductible	65% after deductible
Home Health Care	95%	50% after deductible	85% after deductible precertification required	85% after deductible precertification required
Physical Therapy	100% after \$20 copay <i>(60 days per calendar year)</i>	50% after deductible <i>(60 days per calendar year)</i>	85% after deductible	65% after deductible
Durable Medical Equipment	95%	\$200 deductible	85% after deductible precertification required	65% after deductible precertification required
External Prosthetic Appliances	\$1000 max after \$200 deductible	\$1000 max after \$200 deductible		
Precertification Penalty to Employee for Failure to Precertify	Provider initiated None	Member initiated \$500 penalty <i>(Applies per occurrence)</i>	Member initiated \$500 penalty <i>(Applies per occurrence)</i>	Member initiated \$500 penalty <i>(Applies per occurrence)</i>
Medical Claim Submission	Provider initiated	Member initiated	Provider initiated	Member initiated
Prescription Drug Express Scripts	Retail Benefit Provisions	CIGNA POS	UNITED HEALTHCARE PPO	
	Deductible	None	\$150 RX Only	
	Co-pay	\$10 Generic \$25 Formulary Brand \$55 Non-Formulary Brand	20% Generic 20% Formulary Brand w/Generic Buy-up 40% Non-Formulary Brand	
	Mail Order Benefit	\$20 Generic \$50 Formulary Brand \$110 Non-Formulary Brand	\$10 Generic \$50 Formulary Brand \$110 Non-Formulary Brand	
	CIGNA HEALTHCARE PLAN (A POINT OF SERVICE-POS-PLAN)		UNITED HEALTHCARE (PPO-PLAN)	
	Single	Family	Single	Family
	\$127.16	\$260.88	\$144.29	\$296.29
MONTHLY RATES - EFFECTIVE JUNE 1, 2005 (FOR COVERAGE EFFECTIVE JULY 1, 2005) The benefits of these plans are described in the plan documents with Shelby County Government. The terms and provisions of the plan documents are controlling and none of the conditions or limitations are waived or modified by reason of any omission from this comparison.				

Pre-existing Condition Clause - Once an enrolled person has been in a health plan through Shelby County Government for a continuous 12 month period (contributions must have been paid for each of the twelve months), the pre-existing condition stipulation in the United Healthcare PPO and CIGNA Health Care Plan (when not coordinating care with your primary care physician) is no longer applicable.

Must complete Dependent Status Form on each Child age 19 or over.

MEDICAL BENEFITS AT A GLANCE 2005 - 2006

SHELBY COUNTY GOVERNMENT



MENTAL HEALTH AND SUBSTANCE ABUSE COVERAGE EMPLOYEE ASSISTANCE PROGRAM (EAP)

This is a separate Plan for all participants in any Shelby County Medical Coverage Plan - no mental health or substance abuse coverage will be provided through the United Healthcare PPO or CIGNA POS plans.
If you have been employed by Shelby County for at least six months and you are enrolled in a Shelby County Medical Plan, you are eligible for the Mental Health and Substance Abuse Plan. If you have family coverage and your enrolled dependent has been covered for six months in a row, that dependent is also covered.

For any benefits to be paid, treatment must be coordinated in advance through the County’s Employee Assistance Program (EAP).
EAP phone (901) 458-0966 (after-hours pager (901) 728-9810).

There is no charge and no limit for outpatient treatment provided by the Shelby County EAP Mental Health Specialists. If more care is approved by the EAP, benefits are paid as shown under “Additional Outpatient Care.”

Your choice of providers	When you use an EAP Preferred Provider	When you use any other qualified provider and have EAP signed approval
Plan Pays	Plan pays 100%	Plan pays 50% of eligible expenses within U&C cost limits.
Inpatient Care	Mental Illness treatment is limited to 30 days of care in a calendar year. Substance abuse treatment is limited to 30 days of care in a calendar year - and is limited to one treatment series per year and two treatment series within any five-year period. Adolescents and children may, in special circumstances, receive an additional 30 days of residential care. There is a \$150 per admission charge for each diagnosis if not through EAP Preferred Provider.	
Additional Outpatient Care	<ul style="list-style-type: none">● You pay \$10 per visit when using an EAP Preferred Provider (does not apply to Retirees with Part B Medicare).● Mental illness treatment is limited to 26 visits each calendar year.● Substance abuse treatment is limited to a calendar year benefit of \$1,500 - with additional \$1,500 calendar year benefit if you use an EAP Preferred Provider (a \$3,000 benefit if you use only an EAP Preferred Provider). No benefit paid if treatment series not completed.	

Per-visit charges and hospitalization admission charges under the Mental Health and Substance Abuse Coverage Plan do not apply toward any medical plan deductibles or out-of-pocket limits.